

tic implications, its accurate identification using a test repertoire including cyclin D1 and t(11;14) is important.

## References

1. Domchek SM, Hecht JL, Fleming MD, Pinkus GS, Canellos GP. Lymphomas of the breast: primary and secondary involvement. *Cancer* 2002; 94: 6-13.
2. Windrum P, Morris TC, Catherwood MA, Alexander HD, McManus DT, Markey GM. Mantle cell lymphoma presenting as a breast mass. *J Clin Pathol* 2001; 54: 883-886.
3. Fadare O, Shukla P. Another case of mantle cell lymphoma presenting as breast masses. *J Clin Pathol* 2002; 55: 640.
4. Boullanger N, Renou P, Dugay J et al. Palpable mantle cell lymphoma in the breast. *Presse Med* 2001; 30: 163-165.
5. Hill P, Seale M. Mantle cell lymphoma with bilateral palpable breast masses. *Breast J* 2008; 14: 303-305.

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## Resection of giant follicular thyroid carcinoma infiltrating the trachea

Dear Editor,

A 66-year-old female, coming from an iodine deficiency region, presented to the Department for Endocrine Surgery, Clinical Centre of Montenegro with a neck tumor. She was known to have a nodule in the left thyroid lobe for 14 years, which grew over the last 6 months. Inspection of the neck showed neck deformity on the left side, and a big fixed painless tumor of the left thyroid lobe. FNA of the thyroid showed follicular cells arranged in longitudinal, parallel arrays, with nuclear enlargement and colloid located centrally.

Ultrasonography of the neck showed a hypoechoic heterogeneous 14 cm large and irregular-contour nodule, with calcification in the central part. There was no enlargement of the cervical lymph nodes. Chest X-ray was normal. Thyroid hormones and calcitonin levels were normal but serum thyroglobulin was high (1000 ug/ml). Thyroid scintigraphy revealed a cold nodule in the left lobe. CT scan showed tracheal infiltration without obstruction. Tracheoscopy visualized a 1 cm wide space in the front part of the tracheal wall with malignant infiltration.

Neck exploration under general anaesthesia revealed a tumor infiltrating muscles on the front left neck side. The tumor also infiltrated the left jugular vein and the front part of the trachea. An extended total thyroidectomy with circular tracheal resection and termino-terminal anastomosis were carried out. During surgery we placed another sterile endotracheal tube into the trachea to obtain open airway during the tracheal resection and anastomosis. Frozen sections showed invasive thyroid cancer. We identified and preserved two

parathyroid glands on the right side and both recurrent laryngeal nerves. Both sides of the neck were drained, and the neck was fixed in flexion position. There was no evidence of postoperative hypoparathyroidism, recurrent nerve palsy or respiratory insufficiency. In the first 3 postoperative days the patient was admitted at the Intensive Care Unit, and the following 8 days at the Department for Endocrine Surgery. The following day she was discharged in good condition.

The definite pathological diagnosis was invasive follicular carcinoma infiltrating the trachea. Tumor cells invaded the capsule in a mushroom-shaped growth, and also the muscles and the tracheal wall. Vascular invasion was detected in thyroid tissue.

Two months after the operation the patient received 3.7 GBq I-131 therapy. One year later, whole-body iodine scintigraphy was normal with low thyroglobulin level. Two years after surgery the patient received 5.55 GBq I-131 therapy because of appearance of metastasis in the first thoracic vertebra. A complete response was attained. The patient is on regular follow up for 4 years without evidence for local recurrence or distant metastasis.

Comprehensive use of diagnostic methods, especially CT scan, will give detailed information for operation [1]. Incomplete tumor resection impacts negatively disease prognosis [2]. The purpose of extended surgical treatment in differentiated advanced thyroid carcinomas is to guarantee sufficient respiratory and alimentary functions and obtain local disease control. Adjuvant radioiodine therapy follows [3]. In the Gasert et al. study of 82 patients, the mean survival was 9.4 years and 10-year survival was 40% after resection and reconstruction [4].

Radical resection of thyroid cancer infiltrating the trachea, with circular tracheal resection and termino-terminal anastomosis, followed by radioiodine therapy should be considered as the treatment of choice.

## References

1. Li DS, Wang YX, Shen Q, Huang CP, Ji QH. Surgical management of papillary thyroid carcinoma with endotracheal infiltration. *Zhonghua Wai Ke Za Zhi* 2007; 45: 1475-1478.
2. Greene FL, Page DL, Fleming ID et al. *AJCC Cancer Staging Handbook* (6th Edn). Philadelphia, PA: Springer Publishing

Co Inc, 2002.

3. Brochhoff M, Dralle H. Cervicovisceral resection in invasive thyroid tumors. *Chirurg* 2009; 80: 88-89.
4. Gasiert HA, Honings J, Grillo HC et al. Segmental laryngotracheal and tracheal resection for invasive thyroid carcinoma. *Ann Thorac Surg* 2007; 83: 1952-1959.

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## Recurrent episodes of recall dermatitis of irradiated breast after LHRH agonist administration

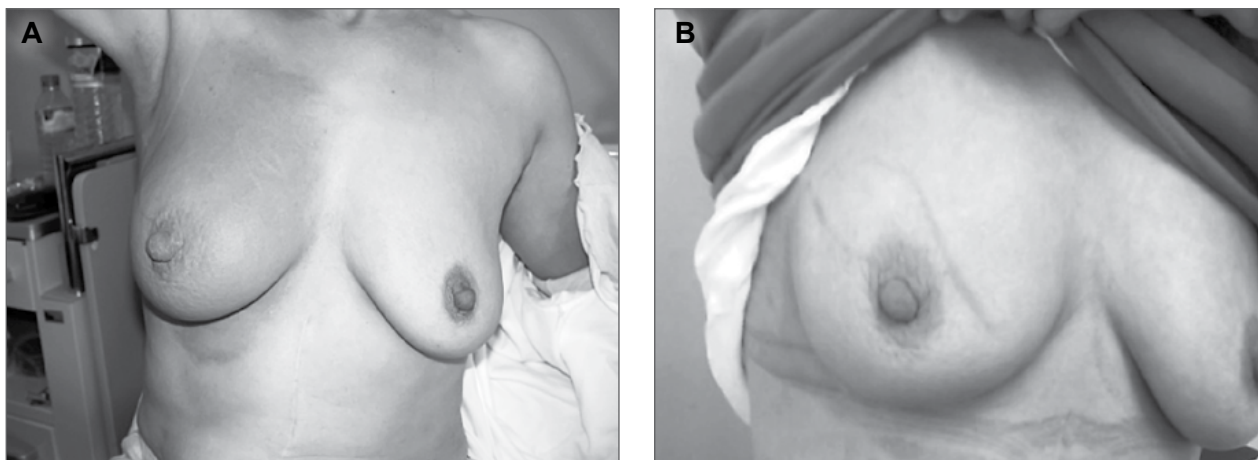
Dear Editor,

Radiation recall dermatitis has been defined as an inflammatory reaction of a previously irradiated area, in response to the administration of certain drugs. Although this phenomenon is relatively well known in the literature, the exact cause has not been documented. We report a case of radiation recall dermatitis in a breast cancer patient receiving adjuvant treatment with an LHRH analogue (LHRHa).

In April 2008 a 47-year-old lady underwent right breast quadrantectomy and axillary lymph node dissection for management of a signet ring breast adenocarci-

noma, pT1cN0Mx, ER/PgR positive and HER2 overexpressing (+3 IHC). Staging was negative for distant metastasis, so she received adjuvant chemotherapy from May to September 2008 with 6 cycles of docetaxel, carboplatin and trastuzumab. In October 2008 she had conventional-fractionation external beam radiation therapy to the entire breast (45 Gy in 23 fractions) and continued on trastuzumab every 3 weeks. The patient was put on hormonal therapy with daily tamoxifen and intramuscular LHRHa goserelin 10.75 mg every trimester.

In January 2009 she presented to our department with pain, swelling, tenderness and erythema on the irradiated breast, fever 39° C and chills, 48 h after having



**Figure 1.** A: recall dermatitis of the right breast after the LHRHa injection. B: same patient 72 hours after her hospitalization.